Date of Service: MM / DD / YY	CPT/HCPCS Code:	Location of Service: 1=Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient.
Provider Staff ID:	Total Time: HR: MIN:	F/F Time: HR: MIN:
Focus of today's treatment DSM-IV-TR Diagnosis Code(s): _____ ICD-9-CM Billing Code(s): _____		

Medications: Target Symptoms

Effect of Medication/Interventions/Level of functioning/ Medication Education

NO ☐ YES ☐ Explain Intervention:

SIDE/ADVERSE EFFECTS: } _____

Compliance: ☐ Yes ☐ No Date/Time of next appointment:_____

Lab Tests/Other Follow-up Recommended: _____

Injection Ordered:_____

M.S.E. _____

Any medication change? _____ If yes, include rationale for change:_____

PLAN:

Rx: PRESCRIPTION Generic Equivalent Permitted

Drug	Strength	Quantity	Refill	Directions

Medi-Cal ☐ Yes TAR done? _____
☐ No Signed Consent? _____

_____ _____ M.D./D.O.
Date Prescriber's Signature

_____
CA License No.

_____
Prescriber's Name (Print)

_____
DEA Number

County of San Diego
Health and Human Services Agency
Mental Health Services

MEDICATION MANAGEMENT

Client: _____

MR/InSyst #: _____ **Date of Birth**:_____

Client Address:_____

Program: _____

Client: _____

MR/InSyst #: _____ **Date of Birth**:_____

Client Address:_____

Program: _____